



Medical Benefits: Questions and Answers About the Energy Employees Occupational Illness Compensation Program



**U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs**

Medical Benefits:
Questions and Answers About the
Energy Employees Occupational Illness Compensation Program

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Employment Standards Administration
Office of Workers' Compensation Programs

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Introduction

As a qualified claimant under the U.S. Department of Labor's Energy Employees Occupational Illness Compensation Program (EEOICP), you are entitled to medical benefits to cover the reasonable cost of treatment for your covered condition(s). Medical providers (such as physicians, pharmacies, and hospitals) may bill the Department of Labor medical bill processing facility directly.

The questions in this booklet are those most often asked by EEOICP beneficiaries about:

- Medical benefits – covered and non-covered services; and
- Reimbursement for medical care and associated travel.

While this booklet gives you basic information about your medical treatment benefits, it is not intended to cover every possible exception or special case, and it does not have the effect of law or regulations.

For further information about special circumstances or individual cases, please call your claims examiner at the EEOICP District Office. A list of District Offices is on the last page of this booklet.

1. Question: What costs are covered under the EEOICPA?

Answer: The cost of medical treatment services and associated travel directly related to the treatment of your accepted condition(s) are covered as authorized under the EEOICP. These costs are payable at established rates for covered medical services. There is no deductible. The following is a list of some of the services that may be covered when they are performed for the treatment of your covered condition:

- Doctors office visits, medical treatments, hospital visits, and consultations;
- Inpatient and outpatient hospital charges, including emergency room visits for the accepted conditions, diagnostic laboratory testing, and chest x-rays;
- Drugs prescribed by a doctor, both brand name and generic;
- Ambulance services; and
- Travel to the doctor, hospital, clinic, other medical facility, or pharmacy.

The following items require special approval:

- Overnight travel, related meals and lodging, and/or mileage that exceeds 200 miles round trip. This requires special approval from your claims examiner at the EEOICP District Office. A list of EEOICP District Offices is on the last page of this booklet.

2. Question: What drugs are covered?

Answer: Most drugs prescribed by your doctor for the treatment of your covered condition(s) will be covered (brand name or generic). However, there are some exceptions. In order to be sure a drug is covered, you or your pharmacist may call toll-free, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

3. Question: What costs are not covered under the EEOICP?

Answer: The following are among the costs not covered under the EEOICP:

- Treatment of medical problems not related to your covered condition(s);
- Medical treatment for your spouse or other family members;
- Medicine that is not prescribed by a doctor; and
- Personal services in the hospital, such as TV or telephone.

Q:
4, 5,
6, 7

4. Question: What is the best way to get my medical bills paid?

Answer: Whenever possible, have your doctor, hospital, pharmacy, and other medical providers bill the Department of Labor directly. If providers are enrolled in the EEOICP, the Department of Labor will pay them directly.

5. Question: How can a medical provider get enrollment and billing information from the EEOICP?

Answer: Medical providers can apply for enrollment at anytime. Those having questions about enrollment or billing may call the EEOICP toll-free, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

(Note: Medical providers currently enrolled with the Department of Labor Black Lung Program do not have to re-enroll with EEOICP - they may use their Federal Black Lung program number.)

6. Question: Where should medical providers send bills related to the EEOICP?

Answer: All EEOICP medical treatment bills should be sent to the following address:

Energy Employees Occupational Illness
Compensation Program
P.O. Box 727
Lanham-Seabrook, MD 20703-0727

Q:
4, 5,
6, 7

7. Question: Does the medical provider need special billing forms?

Answer: YES. The doctor, clinic, laboratory, ambulance, and nursing service should bill using the standard HCFA-1500 form.

The pharmacy can bill using the Universal Pharmacy Billing Form.

The hospital can bill using the UB-92 form for all inpatient charges, other outpatient charges, emergency room, chemotherapy, and ambulatory surgical care.

These are standard forms used throughout the medical community.

8. Question: When do I use my U.S. Department of Labor EEOICP Medical Benefits Identification Card?

Answer: You should present your Identification Card whenever you seek treatment for your accepted condition(s). Showing a medical provider your card will identify you as an EEOICP beneficiary and will help the medical provider determine the proper way to bill for services.

You will need to have your Social Security number available when you present your card.

9. Question: What if the medical provider wants to bill Medicare or other insurance carriers instead of EEOICP?

Answer: Other insurance carriers should not be billed first for treatment of your accepted condition(s), because EEOICP benefits represent primary coverage for beneficiaries.

10. Question: What if I have to pay the medical provider? How do I get reimbursed by the EEOICP?

Answer: We strongly encourage you to present your Medical Benefits Identification Card to the medical provider whenever you seek treatment for your accepted condition so that your medical provider may bill the Department of Labor directly.

**Q:
8, 9,
10**

If the medical provider will not bill directly, you may pay for the medical services out-of-pocket and then request reimbursement yourself.

To obtain a list of medical providers enrolled in our program, call the EEOICP toll-free, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

To obtain reimbursement, complete the U.S. Department of Labor Claim for Medical Reimbursement Form, EE-915, as shown in Sample 1 on page 8. In addition to the EE-915, you must submit the provider's billing statement, receipt of payment by your provider and evidence of your method of payment. Acceptable evidence of payment include: a cash receipt, a copy of your canceled check (both front and back) or a copy of your credit card receipt.

Up to eight visits or services can be listed on this form. However, each line used must be filled in completely. Statements such as “see attached” or “see attached receipts” are not acceptable when used in any of the boxes on the form.

Send the completed Claim for Medical Reimbursement Form with your itemized paid statement or detailed receipts, securely attached, to:

Energy Employees Occupational Illness Compensation Program
P.O. Box 727
Lanham-Seabrook, MD 20703-0727

S: 1
Q: 11

CLAIM FOR MEDICAL REIMBURSEMENT UNDER ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Provide all information requested below. DO NOT FILL IN SHADED AREAS. Read the attached information in order to ensure the submission of all required documentation. Retain a copy of all documentation for your records.

OWCP No. 2-235-01-67
Expiration Date: 7/31/2006

PERSONAL INFORMATION

Name
Smith, Charles P

DOB
MM/DD/YYYY

Address
319 Jefferson Drive
Tunnelsport, PA 16600

EDICOP Case File Number
0000000000000000

Telephone
(814) 999-0124

FOR DOC USE ONLY

PROVIDER INFORMATION

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate EE-915 must be filed for each provider)
J.C. Wazab, M.D.

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
Office Visit	09/27/2001	09/27/2001	35.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Total Reimbursement
\$ 35.00

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered illness or disease. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain compensation under the EDICOP is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.

Signature Charles P. Smith Date 10/01/2001

EE-915

Sample 1 – Claim for Medical Reimbursement

11. Question: How do I get reimbursed for prescription drugs?

Answer: We strongly encourage you to present your EEOICP Medical Benefits Identification Card at the pharmacy when you have a prescription filled for your accepted condition. If the pharmacy is enrolled as a medical provider, the EEOICP may be billed directly. If the pharmacy will not bill the Department of Labor directly, you must pay for the medicine out-of-pocket and then submit for reimbursement yourself.

S: 1
Q: 11

To obtain reimbursement, fill out the Claim for Medical Reimbursement Form, EE-915, as shown in Sample 2 on page 11. Up to eight individual prescription drugs may be listed on this form. However, each line used must be filled in completely. Therefore, statements such as “see attached” or “see attached receipts” are not acceptable when used in any of the boxes on the form.

Send the completed Claim for Medical Reimbursement Form, along with the original pharmacy receipts securely attached, to:

Energy Employees Occupational Illness
Compensation Program
P.O. Box 727
Lanham-Seabrook, MD 20703-0727

Acceptable receipts include: a pharmacy bag or sticker, a computerized printout, or an itemized listing on the pharmacy’s letterhead. These receipts must include:

- Your full name, address, and Social Security number;
- Name of the prescribing doctor;
- Name and address of the pharmacy;
- Prescription number;
- Amount prescribed – mg/ml or cc and total or cc per bottle for liquid medication, and/or mg per tablet and total number of tablets per prescription;
- Date purchased;
- Name of each drug;
- 11-digit National Drug Code (NDC) number for the prescribed medication;
- Charge actually paid for each drug less any discount (for example, senior citizen, coupon); and
- A statement marked “patient paid” or “paid by patient” showing specifically who paid the charges. “Paid” or “paid in full” are not acceptable.

(See Sample 3 on page 12.)

NOTE: If you send an itemized computerized printout, it must include all of the information already listed, as well as the pharmacist’s original signature.

(See Sample 4 on page 13.)

Your own itemized listing or cash register receipt is not considered proof of payment.

A copy of the front and back of your canceled check may serve as proof of payment, only when accompanied by an itemized statement or pharmacist's ledger record.

If you need help getting or completing forms for the reimbursement of drugs, please call toll-free, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

Q: 11

**CLAIM FOR MEDICAL REIMBURSEMENT UNDER ENERGY EMPLOYEES
OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Provide all information requested below. **DO NOT FILL IN SHADED AREAS.** Attach the attached information in order to ensure the submission of all required documentation. Retain a copy of all documentation for your records.

OMB No. 1215-0247
Expiration Date 7/31/2006

PERSONAL INFORMATION

Name Smith, Charles P	EEOWCP Case File Number [0 0 0 0 0 0 0 0]
Address 319 Jefferson Drive	Telephone (814) 999-0124
City/State/Zip Tunnelsport, PA 16600	FOR DOL USE ONLY

PROVIDER INFORMATION

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate EE-915 must be filed for each provider.)

Tunnelsport Drug

Description of Charge (Medical appointment, name of prescription drug, description of medical product/supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
RX#166 LASIX	09/27/2001	09/27/2001	7.99	<input checked="" type="checkbox"/>	<input type="checkbox"/>
RX#167 Theophylline	09/27/2001	09/27/2001	10.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Total Reimbursement

\$ 17.99

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered illness or disease. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain compensation under the EEOWCPA is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OSHA if necessary for the proper adjudication of this claim.

Signature Charles P. Smith

Date 10/01/2001

EE-915

S: 2
S: 3

Sample 2 – Claim for Medical Reimbursement

Tunnelsport Drug
345 Main Street, Tunnelsport, PA 16600
(814) 999-0123

Smith, Charles
319 Jefferson Drive
Tunnelsport, PA 16600
999-99-9999

Date: 09/27/2001
Dr. J.C. Wazab

RX 9166, Refill 1 time, 15 days
Lasix 20 MG Tab SA
NDC: 00039-0067-10
QTY: 15

Patient Paid RPh
\$7.99

Thank You Very Much!

Tunnelsport Drug
345 Main Street, Tunnelsport, PA 16600
(814) 999-0123

Smith, Charles
319 Jefferson Drive
Tunnelsport, PA 16600
999-99-9999

Date: 09/27/2001
Dr. J.C. Wazab

RX 9167, Refill 1 time, 60 days
Theophylline 300 MG Tab SA
NDC: 59930-1670-03
QTY: 60

Patient Paid RPh
\$10.00

Thank You Very Much!

S: 2
S: 3

Sample 3 – Pharmacy Bill Receipt

Profile Print
Insurance Profile
Tunnelsport Drug Store
345 Main Street
Tunnelsport, PA 16600

for

Smith, Charles P.
319 Jefferson Dr.
Tunnelsport, PA 16600
999-99-9999

RX#	105221	Tetracycline 250 MG TABS	DATE	QTY	PRICE	RPH
		Doctor: J. Wazab	10/1/88	90	6.04	ED
		00182-0112-01				

Patient Paid

RX#	105221	Theo dur 100 MG TABS	DATE	QTY	PRICE	RPH
		Doctor: J. Wazab	10/1/88	100	15.82	ED
		00085-0487-01				

Patient Paid

Note: Pharmacist Signature needed.

Sample 4 – Proof of Payment

S: 4
Q: 12

12. Question: Can I be reimbursed for the cost of travel to get medical treatment or prescriptions related to my accepted condition?

Answer: Mileage costs for most travel to obtain medical treatment or prescriptions for your accepted condition may be reimbursed. To receive reimbursement for mileage, you must complete a Medical Travel Refund Request, CM-957, as shown in Sample 5 on page 15. You may submit up to three trips on each form.

Mail the completed Medical Travel Refund Request to:

Energy Employees Occupational Illness
Compensation Program
P.O. Box 727
Lanham-Seabrook, MD 20703-0727

Note: Overnight travel, related meals and lodging, and/or mileage that exceeds 200 miles round trip requires special prior approval from your claims examiner in the EEOICP District Office. A list of toll-free numbers for the District Offices is on the last page of this booklet.

Travel to a pharmacy to pick up prescribed drugs is covered. You must have the pharmacy name, city, state, and zip code indicated in block “E” for each visit and your signature is required in block 8.

S: 4
Q: 12

Medical Travel Refund Request

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



NOTE: This report is authorized by the Black Lung Benefits Act (30 USC 901, 30 CFR 120.406 and 120.701) and the Energy Employees Occupational Illness Compensation Program Act (Public Law 106-368 and 30 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB-Circ 108. This form should be used for medically related services covered under the Federal Black Lung Program and the Energy Employees Occupational Illness Compensation Program.

OMB No. 1515-0054
Expires: 06/30/2004

1. Claimant's Name (Last, First, MI):

Smith, Charles P.

3. Social Security Number:

999-99-9999

2. Payee's Name if different from claimant's name (Last, First, MI): (See instruction No. 3 on the back of form)

4. Claimant's/Payee's Address (Street/RD/City, State, Zip Code):

319 Jefferson drive, Tunnelsport, PA 1660

Special Instructions:

1. See reverse side of form for complete instructions and attachments of receipts.

2. Physician's signature or license is **REQUIRED BY BLACK LUNG** for verification of each service date and type.

5a. Date of Travel: 09/27/2001

5b. ☐ One-way ☒ Round Trip

5c. Travel From:

☐ Hospital ☒ Office/clinic

☐ Lab ☒ Home

5d. Travel To:

☐ Hospital ☒ Office/clinic

☐ Lab ☒ Home

5e. Medical facility name and address:

Community Health CTR

1 Main Street

Tunnelsport, PA 1660

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled: 23

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

Lodging

Meals

Other

(Specify)

5g. Private Auto Only Miles traveled:

5h. Total \$

5i. To be completed by Physician:

Care Rendered: ☐ Treatment for Black Lung

☐ Not Black Lung Related

☐ Determine, Test for Black Lung

Diagnosis:

(Signature of Physician)

(Date Care Rendered)

5a. Date of Travel:

5b. ☐ One-way ☐ Round Trip

5c. Travel From:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5d. Travel To:

☐ Hospital ☐ Office/clinic

☐ Lab ☐ Home

5e. Medical facility name and address:

5f. Total expense/total:

Taxi \$

Bus/Train

Tolls/Trip

14. Question: Will I be notified if the reimbursement requests I send in are going to be paid?

Answer: You will be notified by mail if your reimbursement requests will be paid or denied, through a form called a Remittance Advice (RA), as shown in Sample 6 page 17.

This statement will contain the following information:

- The date of service;
- The amount of your reimbursement request;
- The amount you will be paid;
- A RA number on the top right-hand side of the form (this number will also appear on your check, if you receive a payment, so you can match payments with your reimbursement requests); and
- A “Message Code” which will explain why you were not paid for any portion of the reimbursement request.

You will not receive a RA if your medical provider bills the Department of Labor directly.

S: 5
Q: 13

Remittance Advice
Explanation of Benefits

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation



XXXXXXXX XXXXXX
XXXXXXXXXXXXXX
XXXXXXXXXXXXXX XX 99999

SSN #: 999999999
RA NUMBER : 99999999
Date: 10/09/89
PAGE 1

REFERENCE NUMBER	SERVIC DATE FROM ITHRU	DESCRIPTION OF SERVICE	BILLED AMOUNT	PAYMENT AMOUNT	EOB MSG	
	****PAID ND DENIED BUILD****					
999999999	080789	TRAVEL REFUND	10.40	10.40		
	091289	TRAVEL REFUND	10.40	10.40		
	080789 091289		20.80	20.80		
****TOTAL	PAID/DENIED BILLS:	1	20.80	.00 20.80	AMT PAID	

See Important Message on Back

Form 101-1000
Rev. Sept. 2001

S: 6

Q:

15, 16

Sample 6 – Remittance Advice (Front of Form)

15. Question: What will happen if I have not submitted my reimbursement request forms or receipts correctly? Will I still receive a RA?

Answer: Any reimbursement request forms and receipts that need correction or additional information will be returned to you along with a

letter explaining what is wrong or missing. It is very important that you correct and mail back these forms and receipts as soon as possible. You cannot be paid by the EEOICP until you submit all forms and receipts properly. All corrected reimbursement forms and receipts should be mailed to:

Energy Employees Occupational Illness
Compensation Program
P.O. Box 727
Lanham-Seabrook, MD 20703-0727

If you need help correcting reimbursement requests which have been returned, you may call toll-free, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

16. Question: Will a check come with the RA?

Answer: No, the check is always mailed separately. Checks are issued by the U.S. Department of Treasury. The RA is sent from the EEOICP office in Lanham, Maryland, where your reimbursement requests are processed. The RA should arrive shortly before your check. Please remember to allow enough time (10 to 14 days) for both the check and the RA to arrive before making inquiries.

If you have questions about your RA, if you fail to receive either a check or a RA, or if your payment is incorrect and requires an adjustment, you may call toll-free, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

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17. Question: Whom should I notify if my mailing address changes?

Answer: Any changes in your mailing address should be reported in writing to the EEOICP District Office with which your claim is filed. A list of the District Offices is on the last page of this booklet.

18. Question: Should I keep copies of the bills that I send to the EEOICP?

Answer: Yes, if possible. Keeping a copy will give you a record of the reimbursement requests and receipts you have submitted.

19. Question: Whom do I call if I have questions about my medical bills; if I need reimbursement forms for treatment, prescriptions or travel; or if my EEOICP Medical Benefits Identification Card has been lost or destroyed?

Answer: You may call the EEOICP toll-free number, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

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District
Offices

20. Question: What do I do if I have additional questions?

Answer: You may call the EEOICP toll-free number, Mon.-Fri., 8:15 a.m.-6:15 p.m. (EST) at 1-866-272-2682.

EEOICP DISTRICT OFFICE LOCATIONS

District Office 1 – Jacksonville, Florida

(Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee)

U.S. Department of Labor, DEEOIC
214 North Hogan Street Suite #910
Jacksonville, FL 32202
(877) 336-4272 (Toll Free #)

District Office 2 – Cleveland, Ohio

(Connecticut, Delaware, District of Columbia, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands, Virginia, West Virginia and Wisconsin)

U.S Department of Labor, DEEOIC
1001 Lakeside Avenue, Suite #350
Cleveland, OH 44114
(888) 859-7211(Toll Free #)

Q:
17, 18,
19, 20

District
Offices

District Office 3 – Denver, Colorado

(Arkansas, Colorado, Kansas, Louisiana, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming and all claims from RECA Section 5 awardees)

U.S. Department of Labor, DEEOIC
1999 Broadway Suite #1120
P.O. Box 46550
Denver, CO 80201-6550
(888) 805-3389 (Toll Free #)

District Office 4 – Seattle, Washington

(Alaska, Arizona, California, Idaho, Iowa, Hawaii, Marshall Islands, Missouri, Nevada, Oregon and Washington)

U.S. Department of Labor, DEEOIC
719 2nd Avenue, 6th Floor, Suite #601
Seattle, Washington 98104
(888) 805-3401 (Toll Free #)